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Physicians' newsletter

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College of Physicians & Surgeons Identity Number (CPSID)

Important Reminder for Prescribing Physicians

PharmaCare continues to receive thousands of calls each month from pharmacies being asked to fill prescriptions that do not include a prescribing physician College of Physicians & Surgeons Identity Number (CPSID).

Accurate physician identification is important as this information will be included in a patient's PharmaNet medication history.

PLEASE DO:

Include your CPSID on all prescriptions, as set out in the *College of Physicians & Surgeons Resolution 00-54*, September 1, 2000.

PLEASE DO NOT:

Use your Medical Services Plan Billing Number instead of your CPSID or fail to include your CPSID when using a generic pad from a walk-in clinic, hospital emergency department, etc.

PharmaCare Special Authority Criteria on the Web

For the convenience of physicians and pharmacists, PharmaCare posts the Special Authority criteria for all Limited Coverage and Reference Drug Program medications on its Web site. The page for each medication includes a direct link to the appropriate Special Authority form.

For quick access to the most current Special Authority criteria and forms, please visit the PharmaCare Web site at

www.healthservices.gov.bc.ca/pharme and select the link for **Special Authority Information**

Services

Adequate Medical Records

The MSC Payment Schedule requires practitioners to maintain an adequate medical record to support the fee-for-service payments made to them.

Recent on-site billing audits have identified inadequate or missing clinical records required to support billing. These findings have resulted in the Commission recovering monies from practitioners.

The fee-for-service system is based on a system of trust. Through audits, practitioners are accountable to the public. Maintaining proper records to support payment is an important part of accountability and the Medical Services Commission record-keeping requirements are designed to meet this need.

MSC guidelines may differ from those issued by professional, academic or medico-legal bodies. An adequate medical record, as defined in Schedule Preamble B.2, provides the critical evidence used by a medical inspector to determine whether:

- each claimed service was actually rendered;
- each claimed service was an insured benefit under the *Medicare Protection Act*;
- the submitted fee item was consistent with the service described in the medical record and compliant with any conditions and limitations described in the *Payment Schedule*;
- each service was rendered personally by the physician making the claim (except where delegation is permitted under Preamble B.5);
- the overall frequency and type of service for each patient was medically necessary, based on the patient's health status; and
- there was evidence of any quality-of-care concerns.

Many physicians find that a structured format, such as the "SOAP" model, combined with clinical flow sheets, problem lists, etc., makes them more efficient and improves patient care while reducing the risk of an adverse audit outcome.

Additional reading:

1. Comparison of MSP and CPSBC requirements:
   http://www.cpsbc.bc.ca/policymanual/m/m1.htm
2. CPSBC policy for electronic medical records:
   http://www.cpsbc.bc.ca/policymanual/m/m11.htm
3. College of Physicians and Surgeons of Ontario Guide to Record-Keeping Practices in office-base setting:
   http://www.cpso.on.ca/Publications/publications.htm
   Select "Guide to Current Medical Record-Keeping Practices"
4. College of Physicians and Surgeons of Alberta policy on physicians' office medical records:
   http://www.cpsa.ab.ca/publicationsresources/policies.asp
   Select "Physician Office Medical Records"

Manitoba Health – New 9-digit Personal Health Information Number (PHIN)

The Manitoba health card includes a 6 digit family registration number, the name and address of the head of the family as well as a second section featuring the names of the family members with a personal nine-digit identification number (PHIN) for each insured person.

Until recently Manitoba has required that the 6 digit family number be collected and used for purposes of Reciprocal billing for both hospital and medical claims. Please be advised that Manitoba is currently able to accept either the 6-digit or 9-digit number for Reciprocal billing, however the use of the 9-digit PHIN is now **preferred** for both reciprocal hospital and reciprocal medical claims.

Changes will be made to the MSP edit system to accept the new 9 digit number. Early in 2005 a broadcast message will be sent out to all physicians on their remittance statements to advise them when the 9 digit numbers can be accepted.

Manitoba will continue to accept reciprocal billings with either the 6 digit or 9 digit numbers until March 31, 2005 but after that date only the 9-digit number will be accepted by Manitoba Health.

Hospital Privileges – Reminder

Physicians that do not have hospital privileges but visit their patients in hospital cannot bill those visits to the Medical Services Plan.

Changes to MHR Form Fees

The following amendments to the MHR form fees were effective August 3, 2004.

Description change
96505 - Medical Practitioners completion of MHR Medical Report - persons with persistent multiple barriers. Includes full completion of part C 1-5 Medical Assessment in the detail prescribed by the form.

This follows the previous change to the amount of fee item 96505 from $25.00 to $50.00, also effective August 3, 2004.

New fee item:
96504 - Medical Practitioners completion of MHR Medical Report - Employability forms. Includes completion of part C 1-4 Medical Assessment in the detail prescribed by the form. $25.00

Designated Statutory Holidays – Year 2005

Jan 3	2005	Monday	in lieu of New Year's Day
Mar 25	2005	Friday	Good Friday
Mar 28	2005	Monday	Easter Monday
May 23	2005	Monday	Victoria Day
Jul 1	2005	Friday	Canada Day
Aug 1	2005	Monday	BC Day
Sept 5	2005	Monday	Labour Day
Oct 10	2005	Monday	Thanksgiving Day
Nov 11	2005	Friday	Remembrance Day
Dec 26	2005	Monday	Boxing Day
Dec 27	2005	Tuesday	in lieu of Christmas Day

New and Revised Explanatory Codes

The following explanatory codes have been reworded:

I6 - Claims for 00082 must be supported by details of the care provided to critically ill patient. Please provide breakdown on a per 1/2 hour basis.

P0 – Claim for a non-physician and/or billed fee item does not meet conversion to fee for service criteria.

The following are new explanatory codes:

E5 - WCB item previously paid under separate fee schedule/fee code

NO - Item 14000 is only payable when the physician attends one delivery on the date billed.

2005 Close-Off Dates

Jan 5, 2005	Jul 6, 2005
Jan 20, 2005	Jul 20, 2005
Feb 4, 2005	Aug 4, 2005
Feb 17, 2005	Aug 22, 2005
Mar 4, 2005	Sep 6, 2005
Mar 18, 2005	Sep 21, 2005
Apr 6, 2005	Oct 4, 2005
Apr 20, 2005	Oct 20, 2005
May 4, 2005	Nov 3, 2005
May 19, 2005	Nov 21, 2005
Jun 6, 2005	Dec 6, 2005
Jun 21, 2005	Dec 19, 2005

Removal of Acne Comedones - Reminder

MSP provides payment for removal of acne scars on the face only when significant and disfiguring, not the lesions themselves. Extraction of comedones are regarded as benign lesions and not considered medically required and therefore not a benefit of the Medical Services Plan.

The extraction of comedones would not be considered an exception as listed in Preamble B.16.(4) (a).

Internal Medicine – Oncology

An internal medicine specialist was audited as the result of a complaint regarding billing practices in a hospital out-patient clinic. The audit found that the physician routinely claimed 00307 subsequent office visits whenever a patient attended the clinic to receive scheduled chemotherapy administered by hospital nurses. While it was accepted that the physician was present in the clinic and circulated among the nurses and patients, there was no documentation in the clinical record to substantiate that a medically necessary assessment, including a face-to-face examination, was actually performed. Visit fee codes are not payable for services performed by nurses employed by the hospital.

The audit also found that the physician claimed services that were actually rendered by a colleague providing temporary clinic coverage. Section 36 of the Medical and Health Care Services Regulation requires that payment be made directly to the practitioner who rendered the service, unless the practitioner has assigned payment to another payee number by completing an Assignment of Payment form. However, claims must still indicate which practitioner actually rendered the service. As the result of a negotiated settlement, the physician agreed to repay the Commission $45,000, inclusive of surcharge, interest and audit costs and comply with a pattern of practice order in respect to adequate record keeping, submission of claims for office visits and delegated services.

Psychiatry

Following an audit, the Medical Services Commission and a psychiatrist reached a settlement in a dispute about billings. Issues included billing fee-for-service fee items simultaneously with billings for sessional services.

The practitioner has agreed to repay the Commission a total of $4,982 inclusive of the cost of the audit and surcharge and interest pursuant to s.37 (1.1) to (1.6) of the Medicare Protection Act.

The practitioner has also agreed to abide by a pattern of practice order, which prohibits billing fee-for-service fee items simultaneously with billings for sessional services. The Commission will continue to monitor the practitioner's practice to ensure compliance with the Order.

Psychiatry

Following an audit, the Medical Services Commission and a psychiatrist reached a settlement in a dispute about billings. Issues included billing fee-for-service fee items simultaneously with billings for sessional services.

The practitioner has agreed to repay the Commission a total of $4,742 inclusive of the cost of the audit and surcharge and interest pursuant to s.37 (1.1) to (1.6) of the Medicare Protection Act.

The practitioner has also agreed to abide by a pattern of practice order, which prohibits billing fee-for-service fee items simultaneously with billings for sessional services. The Commission will continue to monitor the practitioner's practice to ensure compliance with the Order.

Psychiatry

Following an audit, the Medical Services Commission and a psychiatrist reached a settlement in a dispute about billings. Issues included billing fee-for-service fee items simultaneously with billings for sessional services.

The practitioner has agreed to repay the Commission a total of $5,558 inclusive of the cost of the audit and surcharge and interest pursuant to s.37 (1.1) to (1.6) of the Medicare Protection Act.

The practitioner has also agreed to abide by a Pattern of Practice Order, which prohibits billing fee-for-service fee items simultaneously with billings for sessional services. The Commission will continue to monitor the practitioner's practice to ensure compliance with the Order.

General Practice - Dr. Michael C. Hartwig - Surrey, BC

The Medical Services Commission successfully reached a negotiated settlement with Dr. Hartwig in which he agreed to refund $90,000 in payments, including interest and costs, and be de-enrolled for a fixed period of 30 days. The settlement followed an audit by the Billing Integrity Program and an investigation by the Ministry's Investigation Unit. It included, inter alia, a concern that a handful of billings had been submitted for refilling prescriptions for patients absent from Canada. Dr. Hartwig

must also comply with a pattern of practice order in which he will:

a) submit claims for assessments and visits only when a direct face-to-face encounter takes place at the time of service;

b) not claim 13610 or similar minor procedures and associated tray fees for inspecting and dressing skin wounds;

c) claim 00190 for removal of warts or other benign skin lesions only when permitted by the MSC Payment Schedule as a medically necessary benefit;

d) maintain adequate clinical records in accordance with the Schedule;

e) comply with Schedule rules regarding daily volume payment rules (high volume/low intensity practice).

Internal Medicine - Endocrinology

An internal medicine specialist was audited because of an exceptionally high rate of multiple consultations per patient for patients followed with chronic endocrine disease. The audit found that consultations and 00101-series complete examinations were sometimes incorrectly claimed in lieu of continuing care by consultant for semi-annual follow-up visits. This is contrary to MSC Payment Schedule Preamble B.3.b, when on-going management of these patients had been transferred for a time by the patients' primary care physicians to the specialist. As the result of a negotiated settlement, the physician agreed to repay $153,000 to the Commission, inclusive of interest, surcharge and audit costs and abide by a pattern of practice order requiring compliance with the Schedule in respect to continuing care.

General Practice

A pediatrician practicing as a general practitioner was brought to the Commission's attention because of exceptionally high cost and frequency of services per patient, rendered through house calls and office visits. The on-site audit identified missing or inadequate records for many house calls; many prolonged office visits for multiple medical complaints that were inappropriately claimed as complete examinations or counseling; and many visits solely for the purpose of injections or immunizations were inappropriately claimed as office visits. As the result of a negotiated settlement, the physician agreed to repay the Commission $150,000 inclusive of interest, surcharge and audit costs and abide by a pattern of practice order in which the physician agreed that he will only bill fee items 00101 (complete examinations) and fee item 00120 (prolonged visit for counseling) in accordance with the MSC Payment Schedule, and that he will keep complete and adequate medical records in accordance with the Act, Regulations and MSC Payment Schedule to support all MSP billings.

General Practitioner – Dr. Liang Ng, West Vancouver

The Commission previously investigated Dr. Liang Ng, because his rates of service significantly exceeded the group average rates for general practitioners in his category. Following a negotiated settlement, Dr. Ng agreed to repay the Commission $343,849.

The Commission continued to monitor his practice profile and a subsequent audit in 2001 was ordered because of continued high billing rates and irregular responses to a service verification audit. The audit found that Dr. Ng continued to provide an excessive number of services to some of his patients, as well as other problems with his record keeping and accuracy of billings.

The Commission and Dr. Ng reached a negotiated settlement in which he agreed to:

a) repay $50,000 to the Commission, inclusive of costs, interest and surcharge;

b) keep adequate medical records;

c) henceforth, abide by a pattern of practice order with respect to his frequency of office visits, and fee items 00103 and 00108.

The Commission will closely monitor Dr. Ng's billing profile to ensure compliance with the settlement agreement and the patterns of practice order.

Positive Quote

The Billing Integrity Program received the following thank you note, after a practitioner's successful audit:

"Thank you for your honest, professional and unbiased assessment of my medical practice. Keep it up. Cheers."

Flu Shots

Influenza vaccine became available mid-October 2004. A physician's recommendation for influenza immunization is the most significant factor in their patient's decision to be immunized. Encourage the patients eligible for publicly funded vaccine to get immunized against influenza.

Influenza vaccine is provided free to people 65 and over; adults and children with chronic health conditions and their caregivers/ household contacts if the person at risk cannot be vaccinated or may respond inadequately to vaccination; healthy infants 6-23 months of age and the household contacts of all infant ages zero to 23 months of age if the infant cannot be vaccinated or may respond inadequately to vaccination, pregnant women in their third trimester, if they are expected to deliver during the influenza season (as they become household contacts of the infant), independent health care practitioners (e.g. doctors, nurses, and dentists) and their staff; staff and residents of care facilities; emergency responders (police, fire and ambulance workers); and, corrections officers. For a detailed listing of eligible recipients, review section 7, page 31 of the BCCDC Immunization Manual at this website: http://bccdc.org/content.php?item=83#1.

In BC infants ages 6 to 23 months of age can be safely vaccinated using either Fluviral or Vaxigrip influenza vaccines. Physician offices will only be provided Fluviral vaccine. If a parent refuses Fluviral vaccine because of the higher Thimerosal content, these clients can be referred to public health.

What to consider:

1. It takes flu vaccine 2 weeks to start working. Waiting for vaccination means waiting for protection.
2. Both types of flu vaccine are safe for infants.
3. The low-thimerosal vaccine vial only keeps 7 days once it's been opened, so it will only be available in Public Health clinics where it can be used up quickly in infant clinics.

Influenza season is also an opportune time to provide the pneumococcal polysaccharide vaccine to patients. This vaccine is provided free to people 65 and over, adults and children with chronic health conditions, and residents of care facilities. Usually, one dose of pneumococcal vaccine is required, for a detailed listing of eligible recipients and revaccination criteria, review section 7, page 43 of the BCCDC Immunization Manual at this website: http://bccdc.org/content.php?item=83#1.

Flu shots should be billed under fee item 00010 (intramuscular medications) for any person eligible to receive the free influenza vaccine. A visit fee should not be billed if the flu shot was the sole reason for the visit.

Only those persons eligible for publicly funded vaccine should have their flu shots billed to MSP.

Charging an eligible person, for either the vaccine (serum) or the injection is in contravention of the *Medicare Protection Act* Part 4 Section 17(1).

MSP BULLETIN WINTER 2004

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal Agreement of Limitation form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07834
9034793801	06/59	F	06468
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

NURSING HOME VISITS –Clarification

Fee item 00114 applies to the care of patients in extended, intermediate, personal, rehabilitation, chronic and convalescent care facilities or any other non-acute care facility whether or not the facility is geographically associated with an acute care hospital. It does not apply to patients who have been transferred from acute to sub-acute care as defined by the *MSC Payment Schedule*.

In accordance with Preamble B.4.e.vii (page 1-20) fee item 00114 is payable only when medically required, and is payable to a maximum of one visit every two weeks. In extenuating circumstances when additional visits are needed, claims should be submitted with a note record explaining the need for the additional visits.

However, the maximum claim limit of one visit every two weeks is not an automatic entitlement for every long-term care patient and, like all other insured services, remains subject to the requirement that the service be medically necessary. A routine visit every two weeks to a long-term care patient is not automatically considered medically necessary.

For care of a patient in a nursing home when specially called, fee item 00115 may be claimed for the first patient seen during the daytime. Any additional patients seen during the same call may be claimed under fee item 00114. When the physician is called to see a nursing home patient outside of office hours, the appropriate out of office visit fee may be billed (fee item 13200, 16200, 17200 or 18200), depending on the patient's age). A call-out charge (fee item 01200, 01201, or 01202) may be claimed in addition for the first patient seen during any special call if all of the out-of-office hours premium criteria are met. In addition if the visit meets the non-operative surcharge criteria, then fee item 01205, 01206 or 01207 may be billed.

WCB Fees Deleted

The following WCB fee items were cancelled June 30, 2004, as per request from WCB.

19962 19963 19964
19965 19966 19967
19968 19969 19970
19971 19972 19973

For more information, please contact the WCB Health Care Benefits Department.

General Practice Services Committee

Maternity Care Network Initiative

Program Description

The number of BC general practitioners providing obstetrical care has seen a dramatic decline in recent years. This is especially problematic in the province's rural areas, where fewer women are able to deliver in their own community. It has also resulted in professional and personal hardship for those physicians who have continued to provide this important service.

In recognition and response to physicians who have identified this problem, the General Practice Services Committee (a joint committee of the BC Ministry of Health Services, the British Columbia Medical Association, and the Society of General Practitioners of BC) has developed a maternity care enhancement program aimed at supporting a group practice approach to GP provision of obstetrical care. Under the Maternity Care Network Initiative, doctors forming their own shared care networks will work as a team so that at least one physician is always available to deliver their patients. Intended benefits of the Maternity Care Network Initiative include:

- Provision of a financial incentive that supports a shared care approach to obstetric care;
- Supports GPs in providing high quality obstetric care;
- Encourages GPs to remain active in obstetrics by improving their quality of life;
- Creates a supportive working environment and peer group for mutual support and quality control;
- Enables sustainability for communities and practitioners;
- Ensures that women across the province can access high quality obstetric care in their own community;
- Encourages new family practice graduates to consider providing maternity care;
- May attract those general practitioners who have recently left obstetrics to return.

The Maternity Care Network Initiative is a temporary program, serving as a bridging strategy, until the Maternity Care Enhancement Committee (created under the 2004 Working Agreement between the BC Medical Association and the Province of British Columbia) develops a long-term and sustainable maternity care strategy for BC.

The Maternity Care Network Initiative is not an on-call payment for communities, but is an enhancement program to support the move to group maternity practice and help prevent family physician burnout.

The Maternity Care Network Initiative has received one-time funding through a $2 million allocation from the 2004 Working Agreement. Eligible BC general practitioners can receive the following enhancement payment for their shared care of obstetric patients:

Maternity care enhancement payment

- Payment of $1,250 quarterly, which includes additional CMPA subsidy (value = $650 per year), and covers costs of group/network activities.
- Claims may be submitted at the end of the quarter, using dates of service of December 31, 2004 or March 31, 2005.
- Claims to be submitted under a program PHN using fee code item 14010.

Eligibility for payment

To be eligible to be a member of the network, a doctor must, for the complete three-month period up to the payment date:

- Be a General Practitioner in active practice in British Columbia;
- Have hospital privileges to provide obstetrical care;
- Be associated with a minimum of 3 other network members (special consideration will be given in those hospital communities with fewer than 4 doctors providing maternity care);
- Cooperate with other members of the network so that at least one member is always available for deliveries;
- Make patients aware of the members of the network, and the support specialists available for complicated cases;
- Accept referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy. The referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care);
- Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic Prenatal Record; and
- Schedule at least four deliveries in each six-month period of time.

Phase in period

The Maternity Care Network Initiative commences October 1, 2004. Information on how to participate in this initiative is available to BC general practitioners through the BC Ministry of Health Services, the British Columbia Medical Association, and the BC Society of General Practitioners. Details of how to complete claims for payment will be posted on the Ministry web site no later than November 30, 2004.

Web site: http://www.healthservices.gov.bc.ca/cdm/practitioners/maternitycare.htm

Frequently Asked Questions

How do I register for the program?

It is not necessary to register for the program. Simply ensure you meet the eligibility criteria for each quarter and keep records to show that you have met the criteria.

What payment may be claimed under the program?

First, this is a service enhancement fee for services provided in a three-month period. There will be two quarterly payments during the term of this interim proposal: one for services provided between October 1st - December 31st, 2004, and the other for January 1st - March 31st, 2005.

How do I claim payments?

All the eligibility criteria must be met to bill for the quarter, although a phase-in period will be allowed during October 2004. The claims computer system will not check eligibility, but should future audit show that all criteria were not met, the payment for the quarter will be recovered. You are required to keep a record that shows how you met the eligibility criteria.

After a quarter in which you have met the eligibility criteria, submit a claim along with your usual claims. Use the following values in the claim:

In the Fee item field:	14010
Claim amount:	$1,250.00
In the patient's PHN field:	9824870522
In the Last name field:	Maternity
In the First initial field:	G
If you require a date of birth, use:	2 November 1989
For Date of service use:	31 Dec 2004, or 31 March 2005.
Report the Diagnosis as:	V26

Notes:

- claims received for processing before the date of service will be refused
- V26 is the ICD-9 code for "procreative management"

What are the eligibility criteria?

To be eligible to be a member of the network, you must, for the complete three-month period up to the payment date:

- be a General Practitioner in active practice in British Columbia;
- have hospital privileges to provide obstetrical care;
- be associated with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care – see below);
- cooperate with other members of the network so that one member is always available for deliveries;
- make patients aware of the members of the network and the support specialists available for complicated cases;
- accept referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care).

- share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic Prenatal Record; and
- each doctor must schedule at least four deliveries in each six month period of time.

Phase in period:

Doctors have until October 31, 2004, to meet the eligibility criteria for the quarter ending December 31, 2004.

What if I cannot find three other doctors to form a network?

If fewer than four general practitioners deliver babies at your hospital or, if there are other extenuating circumstances, request an exemption by faxing to: Administrator, Maternity Care Network Initiative, 1 800 952-2895 (toll free number).

Does participating in this program mean the network members are on call for obstetrics for the community?

No. This is not an on call program. Although one eligibility criterion requires cooperation within the network to ensure that one member is always available for deliveries, participating in this program does not require you to be on call for patients outside your group.

Will the program continue after 2004/05?

As mentioned above, this is a Bridging Initiative, pending the findings of a committee that is developing a long-term program.

Will this program be evaluated?

Yes. The General Practice Services Committee will be evaluating the program against the established purpose as outlined in the program description.

Do we have to send in the names of the doctors in our network?

No. Just keep the list in your records.

Is the payment per doctor or per group?

The $1,250 is per doctor.

Do we have to advertise that we accept referrals?

No, word of mouth is sufficient.

One of our doctors is considering working in a second community based clinic as well as ours. Does this physician get paid for both groups?

No. Only one payment per doctor.

What if a doctor delivers 5 babies in one month, then none in the next seven months?

The condition of scheduling at least four deliveries in every six month period seemed reasonable in ensuring a doctor was in active obstetrical practice. If this situation arises during the program, let the administrator know and the GPSC will review the situation.

Teleplan4

Your connection to MSP payments is changing.

Here's what you need to do

Making sure MSP payments flow smoothly to health care practitioners is a major part of our job. But it's even more important for you.

That's why we've introduced an upgrade to the system you use to transmit MSP claims for payment. It's called Teleplan4. It's Web-based. And it's been in operation for three years, now handling the MSP claims for more than 60 per cent of billing sites every month.

It's time you made the switch to Teleplan4. Here's why.

The Teleplan-DOS system still in use by some billing sites is outdated and no longer supported by its manufacturer, which puts it at risk of failure.

To ensure the continued smooth operations of MSP payments, the Ministry of Health Services – *with the support of the BC Medical Association* – has developed a timeline for converting to Teleplan4. We are recommending billing sites convert to Teleplan4 by January 31, 2005. This will help make sure your upgraded system is in place and working smoothly by **March 1, 2005: after this date, MSP Claims cannot be transmitted through Teleplan-DOS.**

Find out more

1 Contact your billing software vendor. They'll be able to answer most of your conversion questions.

2 Look for our "How-To-Convert" brochure and other Teleplan updates in the mail. Or ask your vendor for a copy.

3 Contact our Teleplan Support Centre for any additional questions:

- Victoria: 250 952-2668
- Other areas of BC (toll-free): 1 800 663-7206

BRITISH COLUMBIA
Ministry of Health Services

BRITISH COLUMBIA Ministry of Health Services

Update to the Medical Services Commission Payment Schedule

Preamble

Amendment

1. Effective immediately, the following prefix is added under Preamble B.14 to identify those fee items for which a surgical assist is not required.

   S – designates fee items for which a surgical assistant's is not payable.

2. This prefix is hereby added to the following fee items:

   - All eye surgery listings

   - All diagnostic procedures with the following exceptions:
     - 11215 Arthrotomy shoulder joint or bursa
     - 11245 Shoulder Girdle, Clavicle and Humerus - Biopsy, open
     - 11315 Arthrotomy elbow joint
     - 11345 Elbow, Proximal Radius and Ulna - Open - biopsy
     - 11415 Arthrotomy wrist joint
     - 11416 Arthrotomy MP, PIP, DIP Joints
     - 11445 Hand and Wrist - Open biopsy, hand or wrist
     - 11515 Arthrotomy hip joint
     - 11545 Arthrotomy and biopsy, hip
     - 11546 Pelvis, Hip and Femur - Biopsy open, soft tissue or bone
     - 11615 Arthrotomy knee joint
     - 11645 Femur, Knee Joint, Tibia and Fibula - Biopsy, open
     - 11715 Incision - Diagnostic, Open - Ankle joint
     - 11716 Incision - Diagnostic, Open - Subtalar joint
     - 11717 Incision - Diagnostic, Open - Midtarsal joint
     - 11718 Incision - Diagnostic, Open - Tarsal-metatarsal, metatarsal-phalangeal, interphalangeal joint
     - 11745 Tibial Metaphysis (Distal), Ankle and Foot - Open biopsy, under GA
     - 11845 Vertebra, Facette and Spine - Biopsy, with GA
     - 00331 Closed drainage of chest - operation only
     - 02323 Removal of nasal polypi – bilateral
     - 02365 Nasal fracture- reduction and splinting
     - 03104 Percutaneous rhizotomy 5th nerve
     - 03165 Insertion of intracranial pressure monitoring device - operation only
     - 03167 Insertion of skull tongs (operation only)
     - 03188 Ventriculostomy or insertion of external ventricular drain (operation only)
     - 03196 Exploration, mobilization and transposition
     - 03216 Puncture of ventricular shunt for CSF aspiration (operation only)
     - 03217 Percutaneous ventricular puncture (operation only)
     - 03240 Implantation of totally implantable ventricular access device (eg., Ommaya reservoir) - (operation only)

- 04001 Laparoscopy (operation only)
- 04500 Cervix dilation and curettage
- 04531 Cauterization of cervix - with dilation and curettage
- 06113 Abrasive surgery - between quarter and half-face
- 06114 Abrasive surgery - full face
- 06200 Tattooing Surgery - Facial area: Less than one-quarter of face
- 06201 Tattooing Surgery - Facial area: One-quarter to one half of face
- 06202 Tattooing Surgery - Facial area: Full face
- 06206 Tattooing Surgery - Nonfacial area - Less than 65 sq.cm
- 06207 Tattooing Surgery - Nonfacial area
- 06258 Exploration of peripheral nerve and neurolysis
- 07843 Implantation of endocardial pacemaker (ventricular)
- 07844 Implantation or replacement of pulse generator for cardiac pacing
- 07847 Endocardial pacemaker (atrial A-V sequential)
- 07924 Decompression of traumatic pneumothorax - operation only
- 07925 Artificial pneumothorax
- 07952 Electronic monitoring of pacing and pacemaker function
- 07953 Double lead endocardial pacemaker
- T08123 Extra-corporeal shock wave lithotripsy (ESWL), operation only
- 08146 Ureteroscopy and basket manipulation of ureteral calculus with or without lithopaxy (operation only)
- 08155 Insertion of internal ureteral stent to include C & P and ureteroscopy, (operation only)
- 08200 Bladder fulguration with cystoscopy
- 08202 Cystostomy by Trochar, isolated procedure
- T08232 Periurethral collagen injections
- 08250 Transurethral resection of bladder or urethral tumour and adjacent muscle and electrocoagulation, as necessary
- 08251 Transurethral resection bladder neck, female
- 08254 Litholapaxy and removal of fragments
- 08256 Transurethral resection of external urinary sphincter
- 08257 Transurethral removal of foreign body (excluding ureteric stents)
- 08260 Urethrotomy, external or internal
- 08261 Urethrostomy
- 08262 Meatotomy and plastic repair
- 08264 Stricture of urethra - office dilation
- 08265 Stricture of urethra - dilation in hospital, isolated procedure, with or without anaesthesia
- 08269 TUR posterior urethral valves
- 08282 Excision prolapse of urethra or caruncle - includes cystoscopy
- 08301 Dorsal slit, isolated procedure
- 08312 Circumcision - excluding clamp or bell technique
- 08319 Balloon dilation of prostate (includes cystoscopy)
- 08323 Exploration of scrotal contents - unilateral
- 08325 Reduction of torsion of testis and spermatic cord repair – bilateral
- 08327 Biopsy of testis
- 08329 Simple orchidectomy
- 08340 Abscess, incision, complete care
- 08341 Spermatocoele or hydrocoele excision
- 08343 Epididymovasostomy or re-anastomosis of vas - unilateral
- 08344 Vas cannulation, unilateral or bilateral
- 08345 Vasectomy - bilateral
- 52800 Manipulation: Shoulder Joint: Manipulation under GA

- 53800 Manipulation: Elbow Joint: Manipulation under GA
- 54800 Manipulation: Hand/Wrist Joint: Manipulation under GA
- 55800 Manipulation: Hip Joint: Manipulation under GA
- 56800 Manipulation: Knee Joint: Manipulation under GA
- 57800 Manipulation: Ankle/Foot: Manipulation, with GA

Diagnostic and Selected Therapeutic Procedures

Amendment

The cancellation date of the following provisional items has been extended. It will expire on May 31, 2005 or when replaced by a subsequent Minute, whichever occurs first:

P00921	Varicocele and/or uterine artery embolization – unilateral	$360.90
P00925	Varicocele and/or uterine artery embolization – bilateral	$501.79

Notes:

i) Fee items P00921 and P00925 include all arteriographies necessary to perform the procedure.

ii) Fee item 08617 or 08618 payable in addition when service rendered in out-patient department.

General Practice

The following items have been approved on a provisional basis, effective immediately. This Minute will expire on July 31, 2005 or when replaced by a subsequent Minute, whichever occurs first:

P12148	Sub-acute hospital visit	$31.31

Notes:

i) Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred from an acute care facility to sub-acute care facility.

ii) Payable 2 times per patient per week. In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

iii) Not payable with 00108, 13108, 00128, 13128, 00127, 13127, 13148, 00112, 00109, 00114, 13114, or 00115.

P13148	Sub-acute hospital visit – 1st visit of the day	$62.62

Notes:

i) Payable only for first patient seen in a sub-acute facility on any calendar day

ii) Not payable on the same day to the same physician as 13108, 13114, 13127 or 13128 unless provided in a discrete facility which is in a separate geographic location from the acute care or extended care facility.

iii) Not payable on same day to same physician for the same patient in addition to 00108, 00109, 00112, 00128, 13108, 13127, 13128, 12200, 13200, 16200, 17200, 18200 and 13114 except as set out in notes iv) and v).

iv) Essential non-emergent additional visits to a patient in a sub-acute facility by the attending or replacement physician during one day are payable under fee item 12148. The claim must include the time of each visit and a statement of need included in a note record. For daytime emergency visit, see fee item 00112.

v) *Fee items 12200, 13200, 16200, 17200, 18200 are payable for addition sub-acute hospital visits same day, same patient when the attending physician or replacement physician is specially called back due to a change in the patient's condition which requires the physician's attendance or due to a condition unrelated to the hospitalization. The claim must include the time of service and an explanation for the visit included in the note record.*

vi) *Sub-acute hospital visits on other than the first visit of the day remain payable under 12148.*

Amendment

Effective immediately, the first note subsequent to the following fee item is amended as indicated:

00116	Special in-hospital consultation	$136.37

Note:

i) *This item applies to consultations on in-hospital patients of an acute or extended care (or when the patient is in the ER with a complex problem as described below and decision has been made to admit), who are referred to a general practitioner by a certified specialist for advice about and/or the continuing care of complex problems for which the management is complicated and requires extra consideration. Examples of such problems include (but are not restricted to) the assessment of terminal illness, the planning of activation/rehabilitation programs and the management of patients with AIDS.*

Ophthalmology

Amendments

The cancellation dates of the following provisional items have been extended. This will expire on December 31, 2004 or when replaced by a subsequent Minute whichever occurs first:

P22067	Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g. Heidelberg, GDX)	$63.92
P22068	- professional fee	$12.28
P22069	- technical fee	$51.64

Notes:

i) *Requires both qualitative and quantitative assessments.*

ii) *Includes examination of both eyes whether at one time or two separate visits*

iii) *Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.*

Effective immediately this item is effective on a provisional basis until December 31, 2005, or when replaced by a subsequent Minute, whichever occurs first:

P22125	Photodynamic therapy for age-related wet macular degeneration – professional fee	$274.39

Note: Payable to Retinal Physicians certified in PDT treatment only.

Obstetrics and Gynaecology

New Fee Items

The following items are effective on a temporary basis until September 30, 2006. On September 30, 2006 and after review by the BCMA, a recommendation may be made to remove the temporary status:

T04038 Repeat intrapartum assessment by consultant at request of primary care physician $170.49

Notes:

i) Payable only subsequent to obstetrician's consultation. If consultation rendered same day, must be paid at least 30 minutes between consultation and repeat evaluation and must be separate event (i.e.: time/situation)

ii) Charges for delivery payable in addition

iii) Call-out charges (1200 series) and emergency visits (04005) are not payable in addition.

iv) Not payable with 04039

T04039 Management of complicated labour by obstetrician $516.41

Notes:

i) Requires completion of written record

ii) Payable only after at least one hour of attendance at bedside

iii) Not payable with 04038, 04050, 14104, 14109 or 14199

iv) Payable X1 only, regardless of multiple gestation

v) Payable only for the following conditions

Foetal conditions:

a. *Abnormal FH tracing requiring scalp pH monitoring, (or attendance at bedside by obstetrician for no less than 60 minutes)*
b. *Prematurity <37 completed weeks gestation*
c. *Severe IUGR (<2500g)*
d. *Face or breech presentation*
e. *Multiple gestation*
f. *Congenital anomaly where neonatal morbidity/mortality is an issue and may be affected by labour/delivery process (e.g. open neural tube defect, body wall defect such as omphalocele; or gastroschisis, congenital; foetal arrhythmia, hydrocephalus*
g. *Hydrops fetalis*
h. *Iso-immunization*

Placental or amniotic fluid conditions:

a. *Placental abruption*
b. *Severe oligohydramnios (AFI<6)*
c. *Severe polyhydramnios (AFI>25)*

Maternal Conditions

a. *Cardiovascular disease where the management of labour must take into account avoidance of rapid changes in volume (e.g.: aortic stenosis or regurgitation, mitral valve stenosis, mitral valve regurgitation with LV dysfunction, severe pulmonary stenosis, coarctation of the aorta, cardiomyopathy, arrythmia requiring pharmacological treatment, any lesion with pulmonary hypertension or ventricular dilation)*
b. *Renal disease (e.g.: renal failure, renal transplant)*
c. *Pulmonary disease (e.g.: pulmonary fibrosis, severe asthma, cystic fibrosis)*

d. *disease (e.g.: Addison's disease, clinical hyperthyroidism, Type 1 Diabetes Mellitus)*
e. *Neurological disease (e.g.: cerebral aneurysm, brain tumour, paraplegia)*
f. *Infectious disease (AIDS, severe pneumonia, systemic sepsis)*
g. *Severe pre-eclampsia (attempt made to deliver vaginally)*

Vascular Surgery

Effective October 1, 2004 the following provisional item has been converted to temporary status until March 31, 2006. On March 31, 2006 after review by the BCMA a recommendation may be made to remove temporary status.

T77177 Abdominal aortic aneurysm repair using endovascular stent graft – vascular surgery component $1,056.08 Anaes. Level 9

Note:
i) In order to bill P77177, vascular surgeon must be present throughout the entire procedure.
ii) Includes the iliac endarterectomy / iliac artery repair
iii) Fem-fem crossover payable in addition at 50% of 77230 or 77235 when done.

Radiology

The following item is effective on a temporary basis from October 1, 2004 until March 31, 2006. On March 31, 2006 and after review by the BCMA a recommendation may be made to remove the temporary status:

T10900 Abdominal aortic aneurysm repair using endovascular stent graft – radiology component $850.00

Note: Intraoperative renal artery angioplasty payable in addition at 50% of fee item 00982 when done.

The following modification to the Payment Schedule is effective immediately:

Amendment

Note iv) (c) subsequent to fee item T00998 is hereby modified as indicated:

Physicians may bill under miscellaneous fee code 00999 for each angiogram when done as a part of an aborted embolization procedure. Each separate vessel injected will be considered a separate angiogram. Payment will be made at 100% for the first angiogram and 50% for subsequent angiograms, to a maximum of $1,700.00. Claims must be accompanied by written details of vessels injected.

Laboratory Medicine

Effective October 1, 2004 the cancellation date of the following provisional item has been extended to March 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

P91760*** Helicobacter pylori Carbon 13 urea breath test $59.99

The cancellation date of the following provisional item has been extended. It will expire on December 31, 2004 or when the Laboratory Reform policy takes effect, whichever occurs first:

P92227	Sirolimus	$53.19

Effective October 1, 2004 the cancellation date of the following provisional item has been extended until March 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

P92355	Troponin	$30.77

Effective October 1, 2004 the cancellation date of the following provisional items has been extended until March 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

Drugs of Abuse Testing – Screening Assays:

P92510	Methadone Metabolite	$4.33
P92513	Methadone	$4.33

Drugs of Abuse – Confirmatory and Specific Quantitiative Assay Testing

P92515*	Blood Methadone	$56.73

The cancellation date of the following provisional item has been extended until March 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

P95053	Thallium body imaging	$374.11

Notes:

i) Not payable with 09806, 09817, 09854 or 09826.

ii) 09877 payable in addition if the patient is brought back for additional imaging the same or next day.

Nuclear Medicine

Effective October 1, 2004 the cancellation date of the following provisional item has been extended to March 31, 2005 or when replaced by a subsequent Minute whichever occurs first:

P95012	Helicobacter pylori Carbon 14 urea breath test	$104.14

BCPharmaCare

Fair PharmaCare
Monthly Deductible Payment Option
Information Sheet

Beginning in 2005, PharmaCare will offer a monthly deductible payment option for individuals and families receiving assistance under the Fair PharmaCare plan.

This new payment option will benefit families who have high prescription costs and expect to meet their deductible by allowing them to spread the deductible costs over the course of the year. Once enrolled, families pay their Fair PharmaCare deductible in monthly installments and receive PharmaCare assistance with eligible prescription costs right away.

Enrollment is entirely optional. If you are not interested in this option, you do not need to take any action. Your Fair PharmaCare assistance will continue as it has in the past.

Who is eligible for the Monthly Deductible Payment Option?

Families who:

- are registered for Fair PharmaCare
- do not have private health insurance with a drug benefit plan*
- have a deductible greater than $0

Example: Brenda and John's prescription costs are about $2,200 each year. Their Fair PharmaCare deductible, based on their combined annual income, is $1,200. Currently, Brenda and John have to pay the $1,200 deductible towards eligible prescription costs before PharmaCare begins contributing 70 per cent of the cost of each prescription.

Under the Monthly Deductible Payment Option, Brenda and John would pay $100 towards their deductible each month. PharmaCare would begin paying 70 per cent of eligible prescription costs from the date their enrollment was processed. Brenda and John would pay only 30 per cent of their eligible prescription costs at the pharmacy until their annual family maximum is reached.

You may enroll in the Monthly Deductible Payment Option for 2005 any time up to September 30, 2005. Please see back for an estimate of monthly payment amounts.

By enrolling soon, you'll have more time to spread out your payments.

For more information, or to enroll, please contact the Fair PharmaCare Registration Desk, toll-free from anywhere in B.C. at **1-800-387-4977**.

Our staff will be available to assist you:

- Monday to Friday 8:00 a.m. to 8:00 p.m.
- Weekends 8:00 a.m. to 4:00 p.m.

* Enrolling in the Monthly Deductible Payment Option is not permitted if you have private health insurance with a drug benefit plan. Your private health insurer contributes towards your prescription costs and the Monthly Deductible Payment Option could complicate or delay the reimbursement of your private health benefits.

Estimated Monthly Deductible Payments

Find your income level below to see an estimate of your monthly payment under the Monthly Deductible Payment Option.

For families in which one or more family members were **born in or before 1939**

Net Annual Family Income*	Annual Deductible Range	Approximate Monthly Deductible Payment
$0 - $33,000	$0	$0
$33,001 - $40,000	$350 - $400	$30 - $33
$40,001 - $50,000	$400 - $500	$33 - $40
$50,001 - $60,000	$1,000 - $1,200	$80 - $100
$60,001 - $75,000	$1,200 - $1,500	$100 - $125
$75,001 - $100,000	$1,500 - $2,000	$125 - $165
$100,000 +	$2,000 - $10,000	$165 - $830

*Line 236 on your and, if applicable your spouse's, federal income tax return.

For families in which all family members were **born in or after 1940**

Net Annual Family Income*	Annual Deductible Range	Approximate Monthly Deductible Payment
$0 - $15,000	$0	$0
$15,001 - $20,000	$300 - $400	$25 - $33
$20,001 - $30,000	$400 - $600	$33 - $50
$30,001 - $40,000	$900 - $1,200	$75 - $100
$40,001 - $50,000	$1,200 - $1,500	$100 - $125
$50,001 - $75,000	$1,500 - $2,250	$125 - $188
$75,001 - $100,000	$2,250 - $3,000	$188 - $250
$100,000 +	$3,000 - $10,000	$250 - $830

*Line 236 on your and, if applicable your spouse's, federal income tax return.

The monthly payment amounts shown are based on a 12-month enrollment. Families who join the program partway through the year may pay an amount that differs from the above.

PharmaCare introduces a Monthly Deductible Payment Option

Beginning in 2005, PharmaCare will offer a new payment option for individuals and families receiving assistance under the Fair PharmaCare plan.

The new Monthly Deductible Payment Option is an enhancement to the Fair PharmaCare plan and is entirely optional.

While PharmaCare pays the majority of eligible prescription costs for families and individuals, many families pay a deductible based on their family income. This new payment option is designed to make paying that deductible easier.

Under Fair PharmaCare, a family is responsible for the cost of their prescription drugs until they have paid their full deductible. After reaching their deductible, PharmaCare pays the majority of eligible prescription costs and they are responsible only for a co-payment. Their co-payments continue until the annual maximum based on their family's income is reached. After that, PharmaCare pays the full amount of all eligible prescription costs. This new option is designed to help families spread out the cost of their deductible over the full year.

This option will particularly benefit families who expect to reach their deductible because of their high prescription drug costs. Once enrolled in this option, families pay their Fair PharmaCare deductible in monthly installments and receive PharmaCare assistance with eligible prescription costs right away.

Families who enrol in the Monthly Deductible Payment Option will still be required to pay the co-payment portion of their eligible prescription costs until they reach their annual family maximum.

Note: Patients remain responsible for payment for non-benefit products.

Enrolment packages have been mailed to those families most likely to benefit from this new payment option.

Further information on the Monthly Deductible Payment Option is provided in the enclosed patient information sheet. This information is available to patients through BC pharmacies and Government Agent's offices. Additional copies of the information sheet are available through the following:

PharmaCare Web site

www.healthservices.gov.bc.ca/pharme
Select "Publications" then "PharmaCare Newsletters", or

PharmaNet Help Desk

- Victoria 250 952-2866
- Lower Mainland 604 682-6849
- Elsewhere in BC 1 800-554-0250

BCHealthServices

MSCommuniqué

Communicating the policy and directives of the Medical Services Commission of British Columbia

Volume 9 Number 3 October 27, 2004

CMQ04-009

Approval of Guideline: Evaluation and Interpretation of Abnormal Liver Chemistry in Adults

Minute of Commission 04-034

Approval of Guideline for

Evaluation and Interpretation of Abnormal Liver Chemistry in Adults

Pursuant to Section 5(1)(c), 24(1), and Section 37 of the *Medicare Protection Act*, the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

Evaluation and Interpretation of Abnormal Liver Chemistry in Adults

This guideline will be used in determination of benefits payable under the *Medicare Protection Act*.

Effective July 1, 2004

CMQ04-010

Approval of the Revised Guidelines

The following guidelines have been revised by the Guidelines and Protocols Advisory Committee and approved by the Medical Services Commission, and supercede the respective previous guidelines, effective July 1, 2004:

- Follow Up of Patients after Curative Resection of Colorectal Cancer
- Clinical Approach to Adult Patients with Dyspepsia
- Clinical Approach to Adult Patients with Gastroesophageal Reflux Disease
- Ambulatory ECG Monitoring (Holter Monitor and Patient-Activated Event Recorder)

CMQ04-011

Approval of Revised Guidelines

The following guidelines have been revised by the Guidelines and Protocols Advisory Committee and approved by the Medical Services Commission, and supercede the respective previous guidelines, effective October 1, 2004:

- Clinical Management of Chronic Hepatitis B
- Clinical Management of Chronic Hepatitis C
- Thyroid Function Tests in the Diagnosis and Monitoring of Adults with Thyroid Disease
- Acute Otitis Media
- Otitis Media with Effusion
- Investigation and Management of Iron Deficiency

Members

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CMQ04-012

Approval of Revised Guideline: Primary Care Management of Sleep Complaints

Minute of Commission 04-052

Approval of Guideline for

Primary Care Management of Sleep Complaints (Revised 2004)

Pursuant to Section 5(1)(c), 24(1), and Section 37(5) of the *Medicare Protection Act*, the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

This guideline will be used in determination of benefits payable under the *Medicare Protection Act*.

Primary Care Management of Sleep Complaints (Revised 2004)

This guideline replaces the previous guideline:

Primary Care Management of Sleep Complaints, effective Nov 1, 1999

Effective November 1, 2004

Guidelines and protocols can be obtained by contacting the Utilization Management Branch, Ministry of Health Services at **952-1347** or by fax to **952-1417**. Guidelines and protocols are also posted on the MSP web site at: **http://www.healthservices.gov.bc.ca/msp/protoguides**. Please e-mail your questions or comments to **hlth.guidelines@gems6.gov.bc.ca.**